

## A Necessary Compromise: the Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-sustaining Procedures Act

Wendy Ann Kronmiller

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**A NECESSARY COMPROMISE: THE RIGHT TO FOREGO  
ARTIFICIAL NUTRITION AND HYDRATION UNDER  
MARYLAND'S LIFE-SUSTAINING  
PROCEDURES ACT**

When confronted with the sight of a permanently unconscious patient, kept alive only by a maze of feeding tubes and respirators, many of us shudder. We certainly would not want to be sustained in this manner. Wishing to spare our family and friends from an unnecessarily protracted period of uncertainty and grief, we write a living will, directing in advance that all artificial life-sustaining treatment be discontinued should we become incapacitated and unable to give consent. We may be unaware, however, that despite our foresight, the law may prohibit health care providers from fully implementing our wishes. Like the patient who never wrote a living will, we may be sustained indefinitely by tubal feeding and hydration.

Thirty-eight states and the District of Columbia have enacted living will legislation.<sup>1</sup> Living will statutes, also known as natural death acts,<sup>2</sup> enable competent adults to prepare in advance for their care should they become terminally ill and unable to make their wishes known.<sup>3</sup> The past three years have been a particularly prolific period for such legislation. Sixteen new natural death acts were developed within a sixteen-month period between 1985 and 1986.<sup>4</sup> In part, this legislative activity reflects an increased societal awareness of the advances medical technology has made in prolonging life. As recognized in the preamble to the Maryland Life-Sustaining

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1. Areen, *The Legal Status of Consent Obtained From Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. A.M.A. 229, 230 (1987).

2. The first such statute, enacted in 1976 in California, was entitled a "Natural Death Act." The term is now used generically to refer to other living will statutes. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 141 (1983) [hereinafter PRESIDENT'S COMMISSION].

3. The legislation may provide for two types of advance directives. A living will is an instructional directive, enabling an individual to assert in writing his or her wishes for medical treatment. A proxy directive is the appointment by an individual of a surrogate to make medical decisions should he or she become incompetent. The two forms may be used together. For example, a durable power of attorney (a form of proxy directive) may incorporate extensive personal instructions. *Id.* at 136, 139.

4. SOCIETY FOR THE RIGHT TO DIE, *HANDBOOK OF LIVING WILL LAWS* 5 (1987) [hereinafter *HANDBOOK*]. The other 23 statutes were enacted between 1976 and 1984. *Id.*

Procedures Act,<sup>5</sup> "the application of some [modern technological] procedures to an individual suffering a difficult and uncomfortable process of dying may cause loss of patient dignity and secure only continuation of a precarious and burdensome prolongation of life."<sup>6</sup>

In addition, an increasing number of deaths are occurring in institutional settings in which control of the patient's care lies with health care professionals.<sup>7</sup> Natural death acts are intended to validate the legal status of living wills in such a setting.<sup>8</sup> According to the Maryland legislature, prior to the Life-Sustaining Procedures Act, "an individual may have [had] difficulty exercising the right to control decisions relating to life-extending procedures because of uncertainty in the medical profession concerning the legality of application or withholding of such procedures even where a competent patient has evidenced a desire that these procedures be applied or withheld."<sup>9</sup> Educational and professional groups encouraged the preparation of advance directives even before the enactment of natural death legislation.<sup>10</sup> Physicians, however, expressed concern over their potential liability for following a patient's instructions.<sup>11</sup>

Despite their intended purpose, legislative enactments designed to validate living wills may result in a contraction of rights for those who act under the statutes. This comment will examine one possible limitation on patient rights: the prohibition in a number of living will statutes against requesting that artificial nutrition and hydration (AN&H) be withdrawn or withheld.<sup>12</sup> First, this

5. Life-Sustaining Procedures Act, ch. 620, 1985 Md. Laws 2944 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1987)).

6. *Id.* at 2945.

7. As of 1983, 80% of deaths in the United States occurred in hospitals or long-term care institutions. PRESIDENT'S COMMISSION, *supra* note 2, at 17-18.

8. *Id.* at 141.

9. Life-Sustaining Procedures Act, ch. 620, 1985 Md. Laws 2944.

10. The Society for the Right to Die, the Euthanasia Education Council, the American Protestant Hospital Association, the American Catholic Hospital Association, and the American Public Health Association each have promulgated living wills. PRESIDENT'S COMMISSION, *supra* note 2, at 139-40 & n.51.

11. See Life Sustaining Procedures Act, ch. 620, 1985 Md. Laws 2944. In fact, there has been only one reported criminal prosecution of a physician for withdrawing treatment from an irreversibly comatose patient. In that case a California appellate court ruled that the physician's actions in disconnecting a respirator and intravenous tubes, in accordance with family requests, were not criminal. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983). The court, in response to writs of prohibition filed by the doctors, vacated the charges of murder and conspiracy to murder pending before a magistrate. *Id.* at 1022, 195 Cal. Rptr. at 494.

12. Artificial nutrition and hydration (AN&H) is the provision of food and fluids to patients through intravenous lines or tubes inserted into the gastrointestinal tract. See

comment will discuss the nature of AN&H as a form of medical treatment and argue that AN&H should not be distinguished from other forms of life-sustaining procedures. This comment next will examine case law in jurisdictions both with and without living will legislation. The case law indicates that individuals possess constitutional and common-law rights, which cannot be overridden by statute, to terminate *any* medical treatment. Third, this comment examines the legislative scheme in Maryland, where the natural death statute prohibits the withdrawal or withholding of food and water.<sup>13</sup> Finally, this comment suggests approaches which the Maryland legislature and the judiciary should consider to assure that the intent of the Life-Sustaining Procedures Act will be honored in the future.

### I. THE NATURE OF AN&H—AS MEDICAL TREATMENT

Since the New Jersey Supreme Court decided *In re Quinlan*,<sup>14</sup> the issue of removing a respirator from an irreversibly comatose patient with family consent, with or without the prior direction of the patient, has not stirred much controversy.<sup>15</sup> Nevertheless, of the thirty-nine natural death statutes, twenty-four make some reference to the withholding or withdrawal of AN&H.<sup>16</sup> Thirteen states, including Maryland, associate this treatment with comfort care,<sup>17</sup> the termination of which statutes generally forbid.<sup>18</sup> Statutes in seven

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generally Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17 (Oct. 1983). For a more detailed discussion of the means of providing AN&H, see *infra* text accompanying notes 47-51.

Due to technological advances in recent decades, AN&H is now a commonplace means of sustaining dying patients who would otherwise be unable to feed themselves. Lynn & Childress, *supra*. Although medicine also may be delivered through tubes and lines, this comment addresses only the administration, withdrawal, or withholding of AN&H.

13. MD. HEALTH-GEN. CODE ANN. § 5-605 (Supp. 1987).

14. 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976), *overruled in part*, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). In *Quinlan*, a landmark decision, the New Jersey Supreme Court held that the parent and guardian of a patient in a persistent vegetative state could authorize discontinuance of a mechanical respirator. *Id.* at 54, 355 A.2d at 671.

15. See generally Steinbock, *The Removal of Mr. Herbert's Feeding Tube*, 13 HASTINGS CENTER REP. 13 (Oct. 1983) (physicians are protected from civil and criminal liability).

16. HANDBOOK, *supra* note 4, at 6.

17. Traditionally comfort care includes providing proper positioning, skin care, oral hygiene, and pain-reducing medication. PRESIDENT'S COMMISSION, *supra* note 2, at 50-51.

18. The thirteen states are Arizona, Florida, Hawaii, Illinois, Indiana, Iowa, Maryland, New Hampshire, Oklahoma, South Carolina, Utah, West Virginia, and Wyoming. HANDBOOK, *supra* note 4, at 6.

states prohibit termination of AN&H.<sup>19</sup> Four statutes indicate that AN&H not needed for comfort care may be withheld or withdrawn.<sup>20</sup>

It is unclear how these statutory prohibitions interact with common-law and constitutional rights. Courts in a number of jurisdictions have indicated that there may be constitutional and common-law rights to the termination of *any* treatment. Relying upon this case law, groups distributing sample living wills encourage people to include their wishes with regard to tubal sustenance, despite possible conflicts with legislation.<sup>21</sup> At the other extreme, some nursing homes view the prohibition as a declaration of state intent which they believe may mandate force-feeding even competent patients to whom the living will statutes do not otherwise apply.<sup>22</sup>

The withdrawal or withholding of AN&H is problematic for a number of reasons.<sup>23</sup> Because all living things require food and water to survive, it is difficult to regard termination of nutrients as merely allowing natural causes to operate.<sup>24</sup> The removal of a respirator is not always fatal, whereas the termination of AN&H is.<sup>25</sup>

19. The seven states are Colorado, Connecticut, Georgia, Idaho, Maine, Missouri, and Wisconsin. *Id.* at 7.

20. The four states are Alaska, Arkansas, Montana, and Tennessee. *Id.* Nearly all of the statutes restricting the termination of AN&H were enacted after 1983. Horan, *Termination of Medical Treatment: Imminent Legislative Issues*, 31 CATH. LAW. 106, 107 (1987). Only two of the sixteen statutes enacted prior to 1983 expressly exclude nutrition and hydration. *Id.*

21. HANDBOOK, *supra* note 4, at 7.

22. Interview with Ellen A. Callegary, Principal Counsel, Maryland Office of the Attorney General, in Baltimore, Maryland (Oct. 15, 1987). In Maryland, the Life-Sustaining Procedures Act limits the implementation of a living will to a small class of patients. A "qualified patient" under the Act must be diagnosed within a reasonable degree of medical certainty to be in a terminal condition from which, despite application of life-sustaining procedures, death is imminent and there can be no recovery. Thus, on its face the provisions and limitations of the Act do not apply to competent patients for whom death is not imminent. MD. HEALTH-GEN. CODE ANN. § 5-601(f) to -601(g) (Supp. 1987). The living will takes effect when a patient no longer is able to give directions regarding health care procedures. *Id.* § 5-602(c)(1).

23. For the purpose of this comment, withdrawing and withholding treatment will be equated. It should be noted, however, that historically authorities have differentiated between the failure to initiate treatment and discontinuation of treatment already in place. PRESIDENT'S COMMISSION, *supra* note 2, at 73-77. Determining whether the former is indeed ethically more permissible than the latter is beyond the scope of this comment.

24. Steinbock, *supra* note 15, at 14. So-called "active" euthanasia, intentionally hastening death by positive action, is considered morally and ethically impermissible. Living wills contemplate passive euthanasia, a hastening of death by natural process by failing to take positive action. Dufraine, *Living Wills—A Need for Statewide Legislation or a Federally Recognized Right*, 1983 DET. C.L. REV. 781, 784.

25. For example, Karen Quinlan survived a decade after removal of her respirator.

Some experts believe that death from termination of AN&H is particularly painful.<sup>26</sup> For all of these reasons, many authorities consider administration of AN&H necessary to a patient's basic comfort and dignity.<sup>27</sup>

In addition to these biological factors, an array of emotional responses make AN&H different from other forms of medical treatment. Society, almost universally, regards the providing of food and water as an expression of care and compassion. Even those who would allow termination of AN&H acknowledge this psychological connection between food and love and between nutritional and emotional satisfaction.<sup>28</sup> It may be particularly difficult for adult children to agree to withdraw such treatment from their parents, who were their childhood nurturers.

At least one authority cites deeply ingrained societal instincts prohibiting withdrawal of nourishment.<sup>29</sup> Daniel Callahan calls the instinct to nourish "one of the few moral emotions that could just as easily be called a necessary social instinct."<sup>30</sup> According to Callahan, by allowing the "starvation" of dying patients we threaten basic moral prohibitions against starving people to death.<sup>31</sup> A relaxation of these principles ultimately could result in the triage of those who are socially undesirable. References often are made in this context to Nazi Germany's concentration camps, in which physicians were among those who became indifferent to the values of preserving

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Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, 18 HASTINGS CENTER REP. 41 (Feb.-Mar. 1988). In contrast, death after the withdrawal of AN&H would occur sometime within five days to three weeks. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 444 n.2, 497 N.E.2d 626, 641 n.2 (1986) (Lynch, J., dissenting). In fact, Karen Quinlan's father was amazed when asked if he wanted intravenous feeding stopped. Ramsey, *Prolonged Dying: Not Medically Indicated*, 6 HASTINGS CENTER REP. 14, 16 (Feb. 1976). "Oh no, that is her nourishment," he responded. *Id.*

26. A dissenting judge in *Brophy* described some of the likely effects as follows:

Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His eyes would recede back into their orbits and his cheeks would become hollow. . . . The lining of his stomach would dry out and he would experience dry heaves and vomiting.

398 Mass. at 444 n.2, 497 N.E.2d at 641 n.2 (Lynch, J., dissenting).

27. See generally Callahan, *On Feeding the Dying*, 13 HASTINGS CENTER REP. 22 (Oct. 1983); Hoyt, *Humanitarian Duties Brushed Aside*, 120 N.J.L.J. 24 (1987); Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued*, 145 ARCH. INTERN. MED. 129 (Jan. 1985).

28. Lynn & Childress, *supra* note 12.

29. Callahan, *supra* note 27.

30. *Id.*

31. *Id.*

life.<sup>32</sup>

Religious groups and organizations representing special interests have been especially vocal in their opposition to living will legislation which would allow the termination of AN&H. Orthodox Jews historically have opposed any intervention which would shorten life.<sup>33</sup> Groups representing the handicapped fear that society will ignore its "humanitarian duty" to care for persons with disabilities and instead will look upon those with severe handicaps as liabilities.<sup>34</sup> In 1982 the general public was outraged when a severely handicapped infant in Bloomington, Indiana was allowed to die with no administration of nutrition or hydration.<sup>35</sup> In response to public outcry, the Department of Health and Human Services mandated that nourishment be provided for handicapped newborns, declaring that "the basic provision of nourishment, fluids, and routine nursing care is a fundamental matter of human dignity, not an option for medical judgment."<sup>36</sup>

The position of the Catholic Church in the controversy has been complex. The Church traditionally has viewed life as a sacred trust over which humanity may claim stewardship but not absolute dominion.<sup>37</sup> As such, life is to be fostered and sustained. The Church historically divided treatment into categories of "ordinary" and "extraordinary."<sup>38</sup> The Church condemned the termination of ordinary treatment as suicide or euthanasia.<sup>39</sup> In 1980 the Vatican issued a "Declaration on Euthanasia" expressing the Catholic Church's current position on the right to die.<sup>40</sup> The Declaration recognized certain limits upon the duty to preserve life. Aban-

32. Derr, *Why Food and Fluids Can Never Be Denied*, 16 HASTINGS CENTER REP. 28, 29-30 (Feb. 1986).

33. This is a vast simplification of the Jewish teachings on the subject. For a thoughtful interpretation of these teachings, see Nevins, *Perspectives of a Jewish Physician*, in BY NO EXTRAORDINARY MEANS 99 (J. Lynn ed. 1986).

34. Hoyt, *supra* note 27.

35. J. Lynn, BY NO EXTRAORDINARY MEANS, *supra* note 33, at 3.

36. 48 Fed. Reg. 30,846, 30,852 (1983) (comment on proposed revision of 45 C.F.R. § 84.61(b)).

37. See, e.g., Bayer, *Perspectives from Catholic Theology*, in BY NO EXTRAORDINARY MEANS, *supra* note 33, at 89-91.

38. Paris, *When Burdens of Feeding Outweigh Benefits*, 16 HASTINGS CENTER REP. 30, 31-32 (Feb. 1986).

39. Bayer, *supra* note 37, at 90. The Church views willful suicide and euthanasia as crimes against the "lofty dignity of the human person." THE SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, DECLARATION ON EUTHANASIA (1980), reprinted in PRESIDENT'S COMMISSION, *supra* note 2, at 300 (quoting Pastoral Constitution, *Gaudium et spes*, 27) [hereinafter DECLARATION, reprinted in PRESIDENT'S COMMISSION].

40. DECLARATION, reprinted in PRESIDENT'S COMMISSION, *supra* note 39.

doning the ordinary/extraordinary distinction in cases of euthanasia, the Vatican espoused a balancing test to determine the benefits of a treatment versus its burdens.<sup>41</sup> When death is imminent and inevitable, the Declaration permits refusal of treatment that "would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."<sup>42</sup> The Declaration further states that the refusal of life-sustaining treatment should not be considered suicide, but rather an "acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community."<sup>43</sup> In commentary and expert testimony, many Catholic ethicists have interpreted the Vatican's Declaration as allowing the withdrawal of all procedures, operations, or other interventions, including AN&H, which are burdensome or which offer no hope of benefit to a patient.<sup>44</sup>

Ethicists who group AN&H with other treatments which may be withheld point out that the means of providing such treatment do not resemble the loving spoonfuls of chicken soup which we sentimentally revere.<sup>45</sup> Artificial feeding has been distinguished from natural feeding as "not part of the normal routine of living."<sup>46</sup> In their article, *Must Patients Always Be Given Food and Water?*,<sup>47</sup> Doctors Lynn and Childress describe what is entailed in providing the two basic types of AN&H:

First, liquids can be delivered by a tube that is inserted into a functioning gastrointestinal tract, most commonly through the nose and esophagus into the stomach or through a surgical incision in the abdominal wall and directly into the stomach. . . . The nasogastric tube is cheap; it may lead to pneumonia and often annoys the patient and

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41. *In re Conroy*, 98 N.J. 321, 340, 486 A.2d 1209, 1218 (1985).

42. DECLARATION, reprinted in PRESIDENT'S COMMISSION, *supra* note 39, at 306.

43. *Id.*

44. See, e.g., *Conroy*, 98 N.J. at 340, 486 A.2d at 1218; Bayer, *supra* note 37. At least one Catholic theologian has looked to economic and emotional burdens placed upon the family as well as burdens to the patient. *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 9-10, 516 N.Y.S.2d 677, 683 (1987). In 1986 the estimated cost of keeping a patient alive in a persistent vegetative state was in excess of \$13,400 per month. Paris, *supra* note 38, at 31. The emotional cost to a family faced with this situation is beyond calculation.

45. See generally Lynn & Childress, *supra* note 12, at 20.

46. *In re Requena*, 213 N.J. Super. 475, 517 A.2d 886, 892 (Super. Ct. Ch. Div.), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (Super Ct. App. Div. 1986) (per curiam).

47. See *supra* note 12.



family, sometimes even requiring that the patient be restrained to prevent its removal.

Creating a gastrostomy [through a surgical incision] is usually a simple . . . procedure, and, once the wound is healed, care is very simple. . . . However, while elimination of a nasogastric tube requires only removing the tube, a gastrostomy is fairly permanent and can be closed only by surgery.<sup>48</sup>

The second type of medical intervention described by Lynn and Childress is intravenous (IV) feeding and hydration. The ordinary hospital IV is useful only temporarily.<sup>49</sup> "One cannot provide a balanced diet through the veins in the limbs: to do that requires a central line, or a special catheter placed into one of the major veins in the chest."<sup>50</sup> Both IV procedures may require restraining the patient, and may cause minor infections and other ill effects.<sup>51</sup>

In their 1983 article, Lynn and Childress suggested that food and water may not be administered when the procedures that would be required are so unlikely to achieve improved nutritional and fluid levels that they could be considered futile, when the improvement in nutritional and fluid balance could be of no benefit to the patient, or when the burdens of receiving the treatment outweigh the benefits.<sup>52</sup> That same year, the President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research issued a report including AN&H among the life-prolonging treatments which may be ethically withheld when they become unduly burdensome.<sup>53</sup> Following the Commission's report, many state and local medical associations addressed the issue and approved guidelines allowing the withdrawal or withholding of AN&H.<sup>54</sup> Then, in 1986, the

48. *Id.* at 18.

49. *Id.*

50. *Id.*

51. See *supra* note 12, at 18.

52. *Id.* at 18-19.

53. See PRESIDENT'S COMMISSION, *supra* note 2, at 3. The President's Commission defined life-sustaining treatment as encompassing

all health care interventions that have the effect of increasing the life span of the patient. Although the term includes respirators, kidney machines, and all the paraphernalia of modern medicine, it also includes home physical therapy, nursing support for activities of daily living, and special feeding procedures, provided that one of the effects of the treatment is to prolong a patient's life.

*Id.*

54. These groups included the Massachusetts Medical Society, in a resolution of July 1985, and the Los Angeles County Medical Association (in conjunction with the Los Angeles County Bar Association), in guidelines of January 1986. HANDBOOK, *supra* note 4, at 11-12.

American Medical Association's Council on Ethical and Judicial Affairs opined that it is ethically permissible for doctors to withhold all life-prolonging treatment, including AN&H, from dying patients and from patients in an irreversible coma.<sup>55</sup> These authorities exemplify the current attitude in the medical profession that, although in most cases it is presumed that AN&H will be provided, it may be acceptable to forego such treatment in certain limited circumstances.

## II. THE COURTS CONCUR WITH MEDICAL AUTHORITIES

Courts have echoed the attitude expressed by experts and ethicists who include AN&H with other forms of medical treatment which may be withdrawn or withheld. Before 1983 judges approved of distinctions between ordinary and extraordinary care.<sup>56</sup> Then, in October of 1983, the California Court of Appeal in *Barber v. Superior Court*<sup>57</sup> unanimously dismissed a murder indictment against two Los Angeles physicians who, at the request of the family, had removed the respirator and IV feeding apparatus from the family's husband and father. In doing so, the court adopted as normative nearly all of the President's Commission's recommendations on what constitutes the appropriate care of terminally ill patients.<sup>58</sup> Thus, in *Barber* an appellate court for the first time equated the discontinuation of IV feeding with the removal of a respirator or other medical intervention.<sup>59</sup> In 1985 the New Jersey Supreme Court in *In re Conroy*<sup>60</sup> cited both the *Barber* decision and the President's Commission's report as authority in determining that AN&H could be withdrawn from an

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55. The American Medical Association's opinion provides in part that "[l]ife prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained." AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT (Mar. 15, 1986), reprinted in SENATE SPECIAL COMMITTEE ON AGING, A MATTER OF CHOICE: PLANNING AHEAD FOR HEALTH CARE DECISIONS, S. COMM. PRINT NO. 211, 99th Cong., 2d Sess. app. at 77 (1986) [hereinafter SENATE SPECIAL COMM. ON AGING].

56. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 437, 497 N.E.2d 626, 637 (1986).

57. 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 494 (1983).

58. Paris & Reardon, *Court Responses to Withholding or Withdrawing Artificial Nutrition and Fluids*, 253 J. A.M.A. 2243, 2244 (1985).

59. *Id.*

60. 98 N.J. 321, 486 A.2d 1209 (1985). For a more detailed discussion of *Conroy*, see *infra* notes 65-70 and accompanying text.

elderly woman.<sup>61</sup> More recent decisions have looked to these cases as well as to the American Medical Association's opinion<sup>62</sup> as being indicative of the view of sound medical practice.<sup>63</sup>

When a state has no natural death act, or when the existing provision does not prohibit the withdrawal or withholding of AN&H, courts generally have had little difficulty in approving the "new" view regarding AN&H as a form of medical treatment. When the legislation specifically excludes nutrition and hydration from procedures which may be withdrawn, however, the court's task becomes more troublesome. Serious questions arise in this context about the role of the court in ethical decisionmaking.

#### A. States Without Natural Death Legislation

Many states have no statutory prohibition regarding withdrawal of food or water, either because the natural death act is not restrictive or because there is no legislation in this area at all. In these jurisdictions, courts have approved withdrawing or withholding AN&H. New Jersey, Massachusetts, and New York are among the states which have no natural death legislation but which have issued important decisions in this area.<sup>64</sup>

In the 1985 *In re Conroy* decision, New Jersey's Supreme Court equated artificial feeding by means of a nasogastric tube or IV infusion with artificial breathing by means of a respirator.<sup>65</sup> Relying in part upon its previous decisions in *Quinlan*,<sup>66</sup> the court ruled that in the case of an elderly nursing home patient with a life expectancy of less than a year, AN&H in the form of a nasogastric tube could be discontinued.<sup>67</sup> The court asserted that Conroy's constitutional and common-law rights to be free from nonconsensual treatment out-

61. 98 N.J. at 372-73, 486 A.2d at 1235-36.

62. See SENATE SPECIAL COMM. ON AGING, *supra* note 55 and accompanying text.

63. See, e.g., *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638 (court consulted views of the American Medical Association and the Massachusetts Medical Society).

64. The New York case is *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 22, 26, 516 N.Y.S.2d 677, 691, 693 (1987) (common-law right to refuse medical treatment includes the right to forego AN&H; consequently, the wife was entitled to act in accordance with the patient's prior clearly expressed wishes and have the use of feeding and hydration tubes discontinued). For a discussion of the New Jersey and Massachusetts cases, see *infra* notes 65-90 and accompanying text. Other states include Delaware and Ohio. See *In re Guardianship of Grant*, 109 Wash. 2d 545, 564, 747 P.2d 445, 455 (1987).

65. 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985).

66. *Id.* at 356-59, 486 A.2d at 1227-28.

67. *Id.* at 374, 486 A.2d at 1236. The decision is limited to cases where medical evidence can establish that the patient fits within the "Conroy pattern": an elderly, incompetent nursing home resident with severe and permanent mental and physical im-

weighed any state or professional interest to the contrary.<sup>68</sup>

The *Conroy* court enunciated a "subjective test" to determine whether treatment should be withdrawn or withheld.<sup>69</sup> Under this test, a court should look to a living will or durable power of attorney as an expression of a patient's intent not to have life-sustaining medical intervention.<sup>70</sup> Thus, although living wills may not be legally binding in jurisdictions without natural death legislation, they may be used as evidence of a patient's wishes.

The Massachusetts Supreme Judicial Court in *Brophy v. New England Sinai Hospital, Inc.*<sup>71</sup> looked to *Conroy* with approval in countering many of the arguments that AN&H somehow differs from other forms of treatment.<sup>72</sup> Patricia Brophy was the wife of a forty-five-year-old firefighter in a persistent vegetative state<sup>73</sup> with no reasonable possibility for return to cognitive life. She petitioned the court for removal of her husband's gastrostomy tube.<sup>74</sup> The court held that the substituted judgment for an incompetent person in a persistent vegetative state must be honored.<sup>75</sup> Citing as authority a number of judicial decisions and professional opinions, including *Conroy* and the President's Commission and American Medical Asso-

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pairments and a life expectancy of approximately one year or less. *Id.* at 342, 486 A.2d at 1219.

68. *Id.* at 353, 486 A.2d at 1225.

69. 98 N.J. at 384, 486 A.2d at 1242. The court in fact set forth three tests. When there is a living will or other evidence of a patient's intent, the court may apply the subjective test. If the patient's intent has not been expressed or is ambiguous, the court looks to two additional tests. Under the "limited objective test" the court looks to other trustworthy but more remote evidence in conjunction with medical evidence that the burdens of treatment outweigh its benefits. *Id.* at 365, 486 A.2d at 1232. Under the "pure objective test" the court will allow the withholding or withdrawal of treatment even if there is no evidence of what the patient would want if medical evidence indicates that the burdens of treatment clearly outweigh its benefits and that the unavoidable pain involved in such treatment is such that its administration would be inhumane. *Id.* at 366, 486 A.2d at 1232. In *Conroy* the court found that evidence produced at the trial court level was insufficient to satisfy any of the three tests. *Id.* at 387, 486 A.2d at 1243. (Ms. Conroy had died, nasogastric tube in place, while the appeal was pending. *Id.* at 341, 486 A.2d at 1219.)

70. *Id.* at 360-61, 486 A.2d at 1229-30.

71. 398 Mass. 417, 497 N.E.2d 626 (1986).

72. *Id.* at 435, 497 N.E.2d at 636.

73. *Id.* at 422, 497 N.E.2d at 628. A persistent vegetative state is probably the most common form of permanent unconsciousness. Patients in a persistent vegetative state perceive neither themselves nor their environment. A neurological examination reveals no neocortical functions. Yet such patients do have sleep-wake cycles, and at times their eyes open. From a neurological standpoint, they do not experience pain, suffering or cognition. Cranford, *Patients With Permanent Loss of Consciousness*, in BY NO EXTRAORDINARY MEANS, *supra* note 33, at 186, 187.

74. 398 Mass. at 422, 497 N.E.2d at 628-29.

75. *Id.* at 433, 497 N.E.2d at 635.

ciation reports, the *Brophy* court grouped artificial feeding with other medical treatment which may be refused.<sup>76</sup> The court rejected the finding that Brophy might experience a painful death if his artificial feeding were discontinued, citing the testimony of several medical experts that a person in a persistent vegetative state feels no pain or suffering.<sup>77</sup>

The *Brophy* court rejected the lower court's finding that artificial feeding was not intrusive, stating that for Brophy, maintenance, possibly for several years, through a "G-tube" indeed was intrusive even though it was not necessarily painful.<sup>78</sup> The court also determined that upon removal of the tube Brophy's death would be caused by his inability to swallow rather than by the discontinuation of artificial feeding.<sup>79</sup>

The New Jersey Supreme Court looked to the *Brophy* decision as well as its own *Quinlan* and *Conroy* precedents when it reexamined the termination of treatment issue in a trilogy of recent decisions, *In re Farrell*,<sup>80</sup> *In re Peter*,<sup>81</sup> and *In re Jobs*.<sup>82</sup> The court reaffirmed in *Farrell* its ruling in *Conroy* that a patient's right to refuse medical treatment is protected by common-law and constitutional rights even though exercise of that right means personal injury or death.<sup>83</sup> Both *Peter* and *Jobs* involved withdrawal of AN&H from patients in a persistent vegetative state who had not authored living wills.<sup>84</sup>

In *Peter* the court extended application of the *Conroy* subjective test to patients in a persistent vegetative state who were likely to survive over a year.<sup>85</sup> The court found that once a court has decided that a patient would have terminated treatment if competent, regardless of the medical condition or life expectancy, the patient's right to self-determination preempts application of any other standard.<sup>86</sup> The best evidence to use in making this decision, said the

76. *Id.* at 439, 497 N.E.2d at 638.

77. *Id.* at 426, 497 N.E.2d at 631.

78. 398 Mass. at 435, 497 N.E.2d at 636. The court observed that 1 patient had survived 37 years in this condition. *Id.* at 437, 497 N.E.2d at 637.

79. *Id.* at 439, 497 N.E.2d at 638.

80. 108 N.J. 335, 529 A.2d 404 (1987).

81. 108 N.J. 365, 529 A.2d 419 (1987).

82. 108 N.J. 394, 529 A.2d 434 (1987).

83. 108 N.J. at 347-48, 529 A.2d at 410. Thus, a patient and the patient's family could authorize disconnection of a respirator without judicial review.

84. In *Jobs* the court set forth guidelines for surrogate decisionmaking by family members for a patient who failed to adequately express in any fashion her wishes about life-sustaining treatment. 108 N.J. at 426-28, 529 A.2d at 451-52.

85. 108 N.J. at 377, 529 A.2d at 425.

86. *Id.* at 377-78, 529 A.2d at 425.

court, is a patient's living will.<sup>87</sup> Although Helen Peter had not executed a living will, she had delegated the power to make general medical decisions to a friend.<sup>88</sup> Peter had not specifically authorized the friend to terminate treatment; however, the court accepted statements that she had directed the friend orally to decline life-sustaining treatment on her behalf as clear and convincing evidence that she would have chosen withdrawal of treatment.<sup>89</sup> *In re Peter* is the first appellate decision in the country to expressly declare that when a patient appoints a health care proxy, the proxy may make termination of treatment decisions, even though the durable power of attorney statute does not specifically extend a proxy's authority to medical decisions.<sup>90</sup> Consequently, it appears that one may use a health care proxy to effect the individual's desired health care treatment while avoiding the restrictions of a living will statute.

Many states have adopted natural death legislation defining life-sustaining procedures in a general way, without specific mention of AN&H or food and water. Legislatures enacted the majority of these statutes prior to 1983 when the President's Commission's report and the *Barber* decision first made AN&H an issue.<sup>91</sup> At that time, legislatures probably did not contemplate the significance of AN&H when drafting statutes.

Washington's Natural Death Act,<sup>92</sup> passed in 1979, is one such silent statute. With *In re Guardianship of Grant*,<sup>93</sup> the Washington Supreme Court recently determined that a guardian could decide to withhold AN&H from her daughter who had become incapacitated by a degenerative disease. Because the daughter had been rendered incompetent by the disease at age fourteen, she had never authored a living will or otherwise stated her feelings concerning life-sustaining treatment.<sup>94</sup> Therefore, the court held that the Natural Death Act did not apply.<sup>95</sup>

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87. *Id.* at 378, 529 A.2d at 426.

88. *Id.*

89. 108 N.J. at 379, 529 A.2d at 426.

90. SOCIETY FOR THE RIGHT TO DIE, INC., RIGHT-TO-DIE COURT DECISIONS NJ-16 (1987).

91. See Horan, *supra* note 20, at 107.

92. WASH. REV. CODE ANN. §§ 70.122.010 to -.905 (Supp. 1987).

93. 109 Wash. 2d 545, 747 P.2d 445 (1987).

94. *Id.* at 550, 747 P.2d at 448. The patient had been of above average intelligence as a young child. Over a period of about 18 years, an incurable condition of the central nervous system had slowly rendered her "almost vegetative" with virtually no cognitive functions. *Id.* at 548, 747 P.2d at 447. Physicians agreed that her death in the near future was inevitable. *Id.*

95. *Id.* at 553, 747 P.2d at 449. The legislature had made no pronouncement re-

The trial court in *Grant* had ruled that the guardian could not make decisions concerning the withdrawal or withholding of life-sustaining treatment from her ward.<sup>96</sup> The Washington Supreme Court reversed. Relying upon two prior decisions concerning life-sustaining treatment other than AN&H, the court ruled that the State's natural death legislation did not prescribe the exclusive method for withholding or withdrawing life-sustaining treatment.<sup>97</sup> Although it did not explicitly so provide, the guardianship statute could be applied in making these decisions. In addition, the court indicated that the State's newly enacted substitute consent statute provided another vehicle for making decisions concerning life-sustaining treatment.<sup>98</sup>

From the foregoing decisions, it is apparent that despite the absence of validating legislation, courts will acknowledge the constitutional and common-law rights to forego life-sustaining treatment, including AN&H. In upholding these rights, courts look first to the living will and durable power of attorney as significant evidence of intent. Such rulings may be instrumental in determining that a patient's right to forego life-sustaining treatment may not be curtailed by any legislative effort to limit the forms of treatment which may be terminated.

#### *B. States With Legislation Restricting the Right to Withhold or Withdraw AN&H*

The decisions discussed in the previous section allow the withdrawal of AN&H if the jurisdiction lacks natural death legislation or if an existing statute does not exclude AN&H. The New Jersey, Massachusetts, and Washington courts, like courts in other jurisdictions, based the right to forego life-sustaining treatment on constitutional and common-law rights.<sup>99</sup> Many courts have interpreted the penumbral right to privacy as including the right to make one's

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garding AN&H, noted the court. *Id.* at 558-59, 747 P.2d at 452. The court acknowledged that generally the legislature is the appropriate authority to resolve this issue. Nevertheless, the court decided to address the issue because it was an immediate problem brought to the court, and not an academic problem for the legislature to answer at some future date. *Id.* at 564-65, 747 P.2d at 455.

96. *Id.* at 565, 747 P.2d at 456.

97. 109 Wash. 2d at 565-66, 747 P.2d at 456.

98. *Id.* at 566, 747 P.2d at 456.

99. See *infra* notes 102-117 and accompanying text. As the discussion of *Corbett v. D'Allessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986), indicates, the source of these rights is not beyond dispute. See *infra* notes 102-114 and accompanying text. Nevertheless, the author believes that although it may be difficult to pinpoint a specific source, the aggregate combination of constitutional and

own health care decisions.<sup>100</sup> The common law protects a person's right to make decisions about medical treatment, whether wise or unwise, and prohibits nonconsensual invasion of bodily integrity.<sup>101</sup> A problem arises, however, when the exercise of these rights conflicts with a natural death statute which limits the forms of treatment which may be withdrawn or withheld.

In *Corbett v. D'Allessandro*<sup>102</sup> the Florida District Court of Appeals held that the right to have a nasogastric tube removed was a federal and state constitutional right which could not be limited by legislation. Helen Corbett, a seventy-three-year-old patient, had been in a persistent vegetative state for years with no reasonable prospect of regaining cognitive brain function.<sup>103</sup> She had not executed a living will, nor had she designated anyone to make treatment decisions for her.<sup>104</sup> Although the trial court recognized that a right to privacy exists which includes the right to terminate extraordinary treatment, it was troubled by the fact that Florida's natural death statute specifically excluded "sustenance" from the

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common-law principles establishes a right to forego AN&H as well as other forms of medical treatment.

100. See, e.g., *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 430, 497 N.E.2d 626, 633 (1986) ("The right of a patient to refuse medical treatment arises both from the common law and the unwritten and penumbral constitutional right of privacy."); *In re Guardianship of Grant*, 109 Wash. 2d 545, 553, 747 P.2d 445, 449 (1987) ("[T]he right to refuse life sustaining treatment is not a mere creation of statute. . . . [I]t stems from both the constitutional right of privacy and the common-law right to be free of bodily invasion." (footnote omitted)). See also *Rasmussen v. Fleming*, 154 Ariz. 207, 214-15, 741 P.2d 674, 681-82 (1987) (although the Supreme Court has not yet held that the right to privacy encompasses the right to refuse medical treatment, numerous state courts have reasoned from Supreme Court decisions that the right to privacy is "broad enough to grant an individual the right to chart his or her own medical treatment plan"). The *Rasmussen* court noted that the "state action" requirement for constitution protection was established by state authority to regulate and license physicians and medical treatment facilities and to supervise the guardianship of incapacitated persons. *Id.* at 215 n.9, 741 P.2d at 682 n.9. These factors taken together created a "sufficiently close nexus" between the State and the challenged action of the regulated entity so that the action of the latter may be treated as that of the State itself. *Id.* (citing *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974)).

101. *Brophy*, 398 Mass. at 430, 497 N.E.2d at 633. As Judge Cardozo wrote in 1914, "Every human being of adult years and sound mind has a right to determine what should be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). Even in emergencies, consent will not be implied if the patient has previously stated that he would not consent. *In re Storar*, 52 N.Y.2d 363, 376, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272 (1981).

102. 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986).

103. *Id.* at 370.

104. *Id.*



treatments which could be discontinued.<sup>105</sup>

The Court of Appeals, however, found the legislation irrelevant to the case, explaining that it was enacted to control particular fact situations only and was "not intended to encompass the entire spectrum of instances in which . . . privacy rights may be exercised."<sup>106</sup> Although it noted that the Florida legislature had specifically provided that the natural death statute could not impair existing constitutional and common-law rights, the court found that even absent express legislative recognition, the right to refuse treatment could not be limited by statute.<sup>107</sup>

Although the court's language in *Corbett* is promising to those who would include a provision regarding AN&H in their advance directives, it is by no means conclusive. *Corbett* held that living will legislation will not affect otherwise existing constitutional and common-law rights in situations in which the statute does not apply.<sup>108</sup> Although courts in other jurisdictions might follow the *Corbett* court in relying upon state constitutional rights to privacy, including the right to forego treatment, the validity of relying upon the United States Constitution for this right is open to question.<sup>109</sup> Many scholars take a skeptical view of the Constitution's penumbral rights.<sup>110</sup> While state courts have held that the federal right to privacy extends to the refusal of treatment, the only federal court to confront the issue based its decision on common-law rather than constitutional grounds.<sup>111</sup>

The President's Commission also questioned the extent of pro-

105. *Id.*

106. 487 So. 2d at 370.

107. *Id.* at 372.

108. *Id.* at 370-71.

109. See Areen, *supra* note 1, at 232. See also *Storar*, 52 N.Y.2d at 376-77, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73 (declining to consider the "disputed question" as to whether the right to refuse life-sustaining treatment is supported by the Constitution because common-law principles adequately support the right).

110. See, e.g., *Katz v. United States*, 389 U.S. 347, 364 (1967) (Black, J., dissenting); *Griswold v. Connecticut*, 381 U.S. 479, 529 (1965) (Stewart, J., dissenting). Some authorities recognize a Court-created right to privacy but question its source and its extent. See, e.g., Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920, 929, 931-32 (1973); Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1423, 1427 (1974).

111. See Areen, *supra* note 1, at 232. In *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985), the United States District Court for the District of Columbia determined that a federal hospital must honor a competent cancer patient's request that a respirator be removed. "Necessarily implicit" in the common-law right of informed consent, said the court, is the right of one who enters treatment in ignorance to later insist that treatment be terminated. *Id.* at 1455.

tection afforded by common-law rights. According to the Commission, common-law rights which are firmly established to protect the right to forego treatment would not require validation by statute.<sup>112</sup> As a result of perceived weaknesses in constitutional and common-law rights, the explicit disclaimer contained in the Florida statute, which also is contained in other state statutes,<sup>113</sup> may be rendered meaningless.

An additional difficulty with a broad reading of *Corbett* is the court's statement that in cases in which the living will act applies, the legislature's mandate *will* exclude the right to decline AN&H.<sup>114</sup> Under this seemingly paradoxical reasoning, one who fails to author a living will may have broader rights than one who meets the requirements of the Florida act. Thus, while *Corbett* lends support to those who would include a provision regarding AN&H in their living wills, it is by no means clear that their wishes will be respected.

A recent ruling in Maine may more firmly support those who add provisions about AN&H to their wills. With *In re Gardner*<sup>115</sup> Maine's Supreme Court, like the *Corbett* court, determined that limitations regarding AN&H in that state's living will act did not apply in the case of a patient in a persistent vegetative state who had not authored a living will. The court held that the legislation neither created a presumption concerning a person without a living will, nor limited the court's power to read more broadly under Maine common law the right of a patient to make decisions concerning life-sustaining care.<sup>116</sup> Unlike the Florida court in *Corbett*, the *Gardner* court did not find that the act excluded the right to forego AN&H in cases in which there was a living will.<sup>117</sup> If *Gardner* failed to squarely address the question of what would occur when a living will includes provisions concerning AN&H contrary to the natural death act, at least it did not explicitly create the possible paradox of *Corbett*.

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112. PRESIDENT'S COMMISSION, *supra* note 2, at 145.

113. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1988); D.C. CODE ANN. § 6-2429 (Supp. 1988); HAW. REV. STAT. § 327D-22 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. § 5-610 (Supp. 1987); N.H. REV. STAT. ANN. ch. 137-H:16 (Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h, § 11 (Supp. 1988).

114. 487 So. 2d at 370.

115. 534 A.2d 947 (Me. 1987).

116. *Id.* at 952 n.3.

117. In other words, although the Maine legislature had not spoken on the issue of life-sustaining treatment when there is no living will, the court did not surmise that if *Gardner* had left a living will, the natural death act's prohibitions would apply. *Id.*

### III. THE RIGHT TO FOREGO AN&H IN MARYLAND

Decisions in other jurisdictions indicate that when there is no natural death statute or when an existing statute does not provide for AN&H, the courts will affirm a patient's right to forego AN&H. In states in which natural death legislation does appear to prohibit the termination of AN&H, courts are beginning to rule that common-law and constitutional rights to forego treatment are paramount to any legislative mandate to the contrary. Maryland's restrictive natural death statute has not yet been challenged by a judicial determination of the right to forego AN&H.<sup>118</sup>

#### *A. Under the Life-Sustaining Procedures Act*

In Maryland, section 5-602 of the Life-Sustaining Procedures Act (the Act) provides that any qualified individual may include a declaration in his or her will directing the withholding or withdrawal of life-sustaining procedures.<sup>119</sup> Section 5-601(e) of the Act defines a "life-sustaining procedure" as

any medical procedure, treatment, or intervention which uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and which, when applied to a patient in a terminal condition, would serve to secure only a precarious and burdensome prolongation of life.<sup>120</sup>

Seemingly, AN&H would fall within this definition. Nevertheless, section 5-605 of the Act states that a declaration of a qualified patient to withhold or withdraw life-sustaining procedures may not be implemented by "the denial of food, water, or of such medication and medical procedures as are necessary to provide comfort care or alleviate pain."<sup>121</sup> The declaration form suggested by the Life-Sustaining Procedures Act provides that the declarant will be "permit-

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118. As this comment went to press, however, the Attorney General for the State of Maryland issued an advisory opinion, declaring that both the constitution and common law created a right to forego AN&H under certain circumstances. The opinion, one of the first offered by a state attorney general on the topic, states that the right may be exercised by a patient through a living will or a durable power of attorney. Additionally, a guardian with court consent, and under some circumstances family members, may exercise the right for a disabled patient. 73 Op. Att'y Gen. (Md.) No. 88-046 (Oct. 17, 1988), reported in *The Sun* (Baltimore), Oct. 18, 1988, at 1A, cols. 5-6 & 11A, cols. 4-6.

119. MD. HEALTH-GEN. CODE ANN. § 5-602 (Supp. 1987).

120. *Id.* § 5-601(e).

121. *Id.* § 5-605.

ted to die naturally with only the administration of medication, the administration of food and water, and the performance of any medical procedure that is necessary to provide comfort care or alleviate pain."<sup>122</sup> The Act's preamble explains that these provisions are "intended to ensure that such basic measures as nursing care, nutrition, and hydration will be maintained."<sup>123</sup>

Despite the statutory prohibition, the Society for the Right to Die, among other groups, encourages Maryland residents to add provisions about the withdrawal of AN&H to their living wills.<sup>124</sup> The Life-Sustaining Procedures Act authorizes the insertion of special provisions into the declaration, as long as they are not inconsistent with the rest of the Act.<sup>125</sup> The Society asserts that the additional provisions are not inconsistent. The Act's language concerning forms of sustenance is ambiguous because AN&H is so unlike "food and water."<sup>126</sup> In addition, the Society argues that the statute does not exclude all food and water from procedures that may be discontinued, but that it prohibits discontinuation of food and water only to the extent that it is "necessary to provide comfort care or to alleviate pain."<sup>127</sup>

The Act does not define the terms "food and water." The provision of AN&H is drastically different from traditional notions of nourishment, since AN&H more closely resembles forms of mechanical medical treatment. Therefore, courts and medical experts have determined that AN&H is grouped more appropriately with life-sustaining procedures other than food and water. Looking solely to the plain language of the Act, there is some ambiguity as to whether artificial forms of nourishment are to be included. A staff report prepared for the House of Delegates, however, specifically advises that AN&H is to be included with other forms of nutrition and hydration.<sup>128</sup> The living will is exercisable by a patient who is diagnosed to be in a terminal condition, caused by injury, disease,

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122. *Id.* § 5-602(c)(1).

123. Life-Sustaining Procedures Act, ch. 620, 1985 Md. Laws 2944, 2945 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1987)).

124. HANDBOOK, *supra* note 4, at 21.

125. MD. HEALTH-GEN. CODE ANN. § 5-602(c)(2) (Supp. 1987).

126. HANDBOOK, *supra* note 4, at 21.

127. MD. HEALTH-GEN. CODE ANN. § 5-605 (Supp. 1987). See also HANDBOOK, *supra* note 4, at 6. Landsmen & Mertes, *Delivery of Legal Services: Slow Death in a Nursing Home*, XXI Md. B.J. 45, 47 (Mar.-Apr. 1988). This reading of § 5-605 seems strained and inconsistent with the statute's punctuation.

128. ENVIRONMENTAL MATTERS COMM., MD. HOUSE OF DELEGATES, COMM. REPORT ON H.B. 453 TO THE GENERAL ASSEMBLY OF 1985, at 6-7 (1985) [hereinafter REPORT ON H.B. 453].

or illness which makes death imminent and from which there can be no recovery despite the application of life-sustaining procedures.<sup>129</sup> According to the report, such a patient usually is comatose.<sup>130</sup> Application of AN&H is a common method of providing food and water for the patient.<sup>131</sup> The report, therefore, indicates that the legislators meant to include AN&H with "food and water."

Any possible confusion remaining over the language of the Act may be dispelled by looking at its legislative history. The Life-Sustaining Procedures Act,<sup>132</sup> was passed in 1985 after twelve years of effort.<sup>133</sup> A consolidation of two separate bills,<sup>134</sup> the Act was approved by the legislature only when the Maryland Catholic Conference (MCC) dropped its opposition.<sup>135</sup> Six single-spaced pages of amendments were added to the proposed Act at the MCC's request.<sup>136</sup> One of the key compromises necessary for passage was the adoption of provisions prohibiting withdrawal or withholding of nutrition and hydration.<sup>137</sup>

In accordance with the Vatican's statement of 1980,<sup>138</sup> Richard Dowling, Executive Director of the MCC, testified before the legislative committee examining the proposed Act, that "the living will is not inconsistent with Church teaching."<sup>139</sup> The MCC, however, had opposed previous legislative attempts to codify the "living will concept" for fear that statutory imprecision would "crack open the door to serious abuses affecting the sacredness of human life."<sup>140</sup> In 1984 the National Conference of Catholic Bishops' Committee on Pro-Life Activities published a statement setting guidelines for liv-

129. *Id.* at 1, 3.

130. *Id.* at 6.

131. *Id.* at 7.

132. Ch. 620, 1985 Md. Laws 2944 (codified as amended at MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1987)).

133. REPORT ON H.B. 453, *supra* note 128, at 2.

134. The Sun (Baltimore), Mar. 19, 1985, at 1D, col. 1.

135. *Id.*

136. *Id.* at 2D, col. 4.

137. Supporters of the original legislation were reported to be particularly unhappy with that change, but said that a compromise victory was better than a defeat. Seiden, *Personal Tragedy Helps 'Living Will' Bill in House*, The Sun (Baltimore), Mar. 27, 1985, at 2F, col. 5.

138. See *supra* text accompanying notes 37-44.

139. *Statement of the Maryland Catholic Conference on "Living Will" Legislation Before the Committee on Environmental Matters, Maryland House of Delegates*, 1985 Sess. at 1 (Feb. 19, 1985) (statement of Richard J. Dowling, Executive Director, the MCC) [hereinafter *Statement*].

140. *Id.* at 2.

ing will legislation.<sup>141</sup> Dowling testified that the MCC's new support of the proposed Act was due in part to the "strengthening" of the Act by its sponsors,<sup>142</sup> who essentially had adopted the Bishops' Committee guidelines.

Serious concern over recent court decisions in other states was an additional incentive for the MCC to approve the proposed Act. Dowling testified to the legislative committee that he was troubled by what he saw as an implicit message from the judiciary to individuals in states without natural death legislation: "Tell us whether or not you want life-sustaining treatment continued, withheld, or withdrawn, or we, the courts, will decide for you and, in the majority of cases, we will decide that such treatment should be withheld or withdrawn rather than initiated or continued."<sup>143</sup> Dowling referred specifically to *Conroy*, which had been decided a few months prior to his testimony.<sup>144</sup> He expressed particular concern that the New Jersey Supreme Court included "*even hydration and nutrition*" among the forms of treatment which may be withheld.<sup>145</sup> Because *Conroy* concerned artificial nutrition and hydration in the form of a nasogastric tube, it is apparent that the MCC amendments adopted by the House of Delegates were meant to exclude both natural and artificial forms of food and water from procedures which may be discontinued.

Also amended at the MCC's request was the proposed Act's definition of life-sustaining treatment which may be withdrawn or withheld.<sup>146</sup> The new language, adopted verbatim from the MCC, replaced a definition which the MCC deemed "vague" and "synonymous with medical procedures in general."<sup>147</sup> Although the plain meaning of the definition as amended seemingly includes AN&H,<sup>148</sup> the Act's express prohibitions as well as its legislative history indicate that AN&H is to be distinguished from other forms of life-sustaining treatment. As a result, the Act's definition of life-sustaining treatment, as it pertains to AN&H, is ambiguous at best.

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141. COMMITTEE FOR PRO-LIFE ACTIVITIES, NATIONAL CONFERENCE OF CATHOLIC BISHOPS, GUIDELINES FOR LEGISLATION ON LIFE-SUSTAINING TREATMENT (Nov. 10, 1984).

142. *Statement*, *supra* note 139, at 2.

143. *Id.* at 3.

144. *Id.* at 2-3.

145. *Id.* at 2 (emphasis in original).

146. *See supra* text accompanying note 120.

147. Letter from Richard J. Dowling to Delegate Larry Young, Chairperson, House Envtl. Matters Comm., at 6 (Feb. 25, 1985) (discussing the MCC proposed amendments to the General Assembly's living will legislation).

148. *See supra* text accompanying note 120.

Although it would appear that those who add provisions to their living wills requesting termination of AN&H are acting contrary to the Life-Sustaining Procedures Act, the legislation, like Florida's legislation in *Corbett*, provides that its provisions are cumulative and may not be construed to impair or supersede any existing legal right or responsibility.<sup>149</sup> Dowling's testimony makes it clear that the MCC's mission in supporting the proposed Act was to deter the Maryland judiciary from independently defining broader rights.<sup>150</sup> In the foreseeable future Maryland courts may face the *Corbett* questions of whether a patient's common-law or constitutional rights still exist despite statutory language to the contrary. Unlike *Corbett* and *Gardner*, in which the patients had never authored a living will, there may be the added factor of a patient's express directive that AN&H be withdrawn.

*B. Maryland's Durable Power of Attorney  
and Other Statutes—Broader Rights?*

The New Jersey court in *Peter* interpreted the state's power of attorney statute to enable conveyance of the power to make medical decisions, even though the statute does not expressly so authorize.<sup>151</sup> This is far from the original purpose of the power of attorney. Powers of attorney statutes traditionally have been used to facilitate commercial transactions and the management of property.<sup>152</sup> Because an adult must be competent to convey this authority and must always be able to revoke it, historically powers of attorney revoked automatically upon the incompetency of the maker.<sup>153</sup> In order to enable powers of attorney to extend beyond the maker's competency, state legislatures have enacted laws permitting them to be "durable."<sup>154</sup> In Maryland, in order for a power of attorney to be durable it must explicitly state words showing the intent of the principal that the authority be exercisable notwithstanding disability.<sup>155</sup>

At least one authority in Maryland has found no reason why the existing durable power of attorney cannot be employed as an advance planning tool for health care decisionmaking.<sup>156</sup> If they are

149. MD. HEALTH-GEN. CODE ANN. § 5-610 (Supp. 1987).

150. See *supra* text accompanying notes 132-145.

151. 108 N.J. 365, 393-94, 529 A.2d 419, 429-30 (1987).

152. SENATE SPECIAL COMM. ON AGING, *supra* note 55, at 32.

153. *Id.*

154. *Id.* at 33. See, e.g., MD. EST. & TRUSTS CODE ANN. §§ 13-601 to -602 (1974).

155. MD. EST. & TRUSTS CODE ANN. § 13-601 (1974).

156. Bacharach, *Substitute Consent for Medical Care*, 1 THE BARRISTER 21, 22 (Oct. 1983).

allowed as tools for proxy medical decisionmaking, powers of attorney seemingly may be used more broadly than living wills. Not only will they be activated in a greater number of circumstances,<sup>157</sup> but there is no provision similar to that in the living will statute disallowing termination of food or water.

Two states specifically provide for the use of a power of attorney as a means of delegating health care decisionmaking.<sup>158</sup> Only the New Jersey court has ruled on the extent that a power of attorney may be used to make medical decisions absent enabling legislation.<sup>159</sup> The problem with such a broad reading of these statutes is their origin in property law. The President's Commission warned of possible abuse when powers of attorney are used out of their original context.<sup>160</sup> In 1984 New York's Attorney General concluded that the general delegation of health care decisionmaking may not be made by power of attorney, although an agent identified in a power of attorney may be designated to communicate the *patient's* decision to decline medical treatment.<sup>161</sup> The traditional durable power of attorney, according to the Attorney General's opinion, is "an uncertain vehicle" for delegating general authority for making health care decisions.<sup>162</sup> Nevertheless, the Senate Special Committee on Aging has indicated that despite this uncertainty it is probable that a court will accept an incapacitated person's designation of a proxy health care decisionmaker through a durable power of attorney because courts generally accept clear and convincing evidence of a patient's desire regarding health care.<sup>163</sup>

The relation of the durable power of attorney to health care in Maryland is affirmed somewhat by language in section 20-107 of the Health-General Article, the so-called "substitute consent" statute.<sup>164</sup> That statute provides that a durable power of attorney "that

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157. The durable power of attorney may be used to make decisions on behalf of individuals who are not terminally ill but who nonetheless are incapable of making their own decisions. This would include patients who are permanently unconscious or suffering from an incapacitating degenerative disease. SENATE SPECIAL COMM. ON AGING, *supra* note 55, at 34.

158. The two states are California and Pennsylvania. J. SMITH, HOSPITAL LIABILITY § 13.04(1)(b) (1986).

159. *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).

160. PRESIDENT'S COMMISSION, *supra* note 2, at 147.

161. Op. Att'y Gen. (N.Y.) No. 84-F16 (Dec. 28, 1984), *quoted in* SENATE SPECIAL COMM. ON AGING, *supra* note 55, at 33 n.83.

162. *Id.*

163. SENATE SPECIAL COMM. ON AGING, *supra* note 55, at 33. *See also* J. SMITH, *supra* note 158.

164. MD. HEALTH-GEN. CODE ANN. § 20-107 (Supp. 1987).



relates to medical care" preempts the ability of family members to substitute their consent for furnishing medical care to a disabled individual.<sup>165</sup> Although this language recognizes that a power of attorney may be durable and may relate to health care, the scope of the substitute consent statute probably does not include decisions regarding the termination of life-sustaining treatment. The decisions which may be made through substituted consent under section 20-107 are those for "furnishing medical or dental care and treatment to a disabled individual."<sup>166</sup> The statute provides that substitute consent may not be utilized for abortions, sterilization, or the observation, diagnosis, treatment, or hospitalization for a mental disorder.<sup>167</sup> These delineated limitations, combined with reports from legislative hearings,<sup>168</sup> indicate that the substitute consent statute was promulgated in order to provide an easy means of obtaining consent for cases involving minor disabilities without having to fulfill the cumbersome requirements of guardianship.<sup>169</sup>

A bill proposed to the Maryland House of Delegates in 1985 attempting to augment existing powers of attorney with a separate durable power of attorney for health care failed to reach the House floor.<sup>170</sup> The MCC had serious reservations about this bill.<sup>171</sup>

165. *Id.* § 20-107(d). Similarly, Maryland's recently enacted Patient Care Advisory Committee Law, MD. HEALTH-GEN. CODE ANN. §§ 19-370 to -374 (Supp. 1987), includes "an individual with a power of attorney to make a decision with a medical consequence for a patient" in its delineation of persons to whom notification of a patient's rights should be given by the Committee. *Id.* § 19-374. This is an additional confirmation of the role of a durable power of attorney in matters relating to health care.

166. MD. HEALTH-GEN. CODE ANN. § 20-107(d) (Supp. 1987).

167. *Id.* § 20-107(f)(1).

168. "[S.B. 433] doesn't do anything drastic. It codifies what is common law practice in the State. . . . Guardianship procedure costs a great deal of money. This is a compromise so that people [sic] will not have to go to court on every little thing." FINANCE COMM., MD. SENATE, DISABLED INDIVIDUALS—CONSENT TO MEDICAL OR DENTAL CARE, HEARING ON S.B. 433 (Feb. 23, 1984) (statement by Delegate Toth).

169. Maryland's guardianship statute, MD. EST. & TRUSTS CODE ANN. §§ 13-704 to -710 (Supp. 1986), through which a court may appoint a guardian for a minor or disabled person, authorizes a guardian to "give necessary consent or approval for medical or other professional care, counsel, treatment, or service." MD. EST. & TRUSTS CODE ANN. § 13-708(b)(8) (Supp. 1986). Court approval is required, however, prior to the use of any medical procedure involving a substantial risk to life. *Id.* It is unlikely that the legislature intended substitute consent as a facile means to circumvent this requirement.

170. H.B. 1456, a bill introduced by Delegate Hixson to establish a durable power of attorney for health care, was read on February 1, 1985, and assigned to the House Committee on Environmental Matters. The proposed bill provided in part that except as otherwise specified in the document, the durable power of attorney for health care would give the agent the power to consent to withhold or withdraw life-sustaining treatment. H.B. 1456, 1985 Sess.

171. Letter from Richard J. Dowling to Delegate Larry Young, *supra* note 147, at 4.

Adopting the position of the Conference of Catholic Bishops, the MCC has stated that it wants to ensure that any legislation in this area avoids granting unlimited power to a proxy decisionmaker to make a critical health care decision on a patient's behalf.<sup>172</sup> As it stands, although Maryland's durable power of attorney does not have provisions similar to those in the living will regarding food and water, its status in enabling the termination of life-sustaining treatment is uncertain.

### C. *Relevant Decisions in Maryland Courts*

Because ethicists and medical experts consider AN&H a form of medical treatment, decisions regarding its application are subject to general rules requiring informed consent.<sup>173</sup> The doctrine of informed consent grew out of the common-law right to bodily integrity.<sup>174</sup> The right to informed consent was first recognized by Maryland's Court of Appeals in *Sard v. Hardy*, a medical malpractice case.<sup>175</sup> The court determined that a physician must advise a patient of any material risk or dangers of treatment so as to enable the patient to make "an intelligent and informed choice about *whether or not* to undergo such treatment."<sup>176</sup> This doctrine "follows logically from the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without" the patient's prior consent.<sup>177</sup> Although *Sard* involved elective surgery, courts in other states have used the right to informed consent as a basis for the right to refuse life-sustaining treatment, including AN&H.<sup>178</sup>

The Maryland Court of Appeals was given an opportunity to

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172. *Id.*

173. See Landsman, *Terminating Food and Water: Emerging Legal Rules*, in *By No Extraordinary Means*, *supra* note 33, at 135.

174. *In re Conroy*, 98 N.J. 321, 346, 486 A.2d 1209, 1222 (1985).

175. 281 Md. 432, 379 A.2d 1014 (1977).

176. *Id.* at 439, 379 A.2d at 1020 (emphasis added).

177. *Id.* at 438-39, 379 A.2d at 1019.

178. See, e.g., *In re Gardner*, 534 A.2d 947, 951 (Me. 1987) ("The personal right to refuse life-sustaining treatment is now firmly anchored in the common law doctrine of informed consent"); *In re Conroy*, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985) ("The patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal."). But see *Sard*, 281 Md. at 439, 379 A.2d at 1019 ("The fountainhead of the doctrine of informed consent is the patient's right to exercise control over his own body, *at least when undergoing elective surgery*, by deciding for himself whether or not to submit to the particular therapy." (emphasis added)).

interpret a patient's right to refuse treatment in *Mercy Hospital, Inc. v. Jackson*.<sup>179</sup> That case involved the right of a Jehovah's witness to refuse blood transfusions during a caesarian delivery. The court, however, found the case moot because resolution of constitutional issues was no longer necessary and the precise factual circumstances were unlikely to recur.<sup>180</sup>

Although the court of appeals vacated the decision, the opinion by the court of special appeals in *Mercy Hospital* provides a useful basis for discussing the right to refuse treatment in Maryland. The court of special appeals found that, consistent with the right of informed consent, a competent adult may refuse blood transfusions when the refusal is made knowingly and voluntarily and will not endanger a third party.<sup>181</sup> Thus, the court affirmed a circuit court judge's refusal to appoint a guardian to authorize the transfusion.<sup>182</sup> In rendering its decision, the court of special appeals relied in part upon an amicus curiae brief by the State of Maryland acknowledging that the State's "interest in the preservation of life is not necessarily absolute."<sup>183</sup> The court cited portions of the substitute consent statute which provide that a health care provider may not rely upon substituted consent to give treatment that the provider knows is against a patient's religious belief.<sup>184</sup> According to the *Mercy Hospital* court, this is an "emphatic legislative mandate that the patient's decision regarding the type of treatment the patient shall endure is paramount. The statute goes so far as to declare that, in the final analysis, it is the patient who determines whether there shall be any treatment at all."<sup>185</sup> The court reasoned that certainly the protection afforded a competent adult will be no less than that afforded to the disabled under section 20-107.<sup>186</sup>

179. 62 Md. App. 409, 489 A.2d 1130 (1985), *vacated for mootness*, 306 Md. 556, 510 A.2d 562 (1986). For a more detailed discussion, see Bamberger, *Mercy Hospital, Inc. v. Jackson: A Recurring Dilemma for Health Care Providers in the Treatment of Jehovah's Witnesses*, 46 Md. L. Rev. 514 (1987).

180. 306 Md. at 564-65, 510 A.2d at 566. In a strongly worded dissent, Judge McAuliffe stated that the *Mercy Hospital* case, while itself moot, should have been heard as a "textbook example" of an important question of substantial public concern which is "'capable of repetition yet evading review.'" *Id.* at 565, 510 A.2d at 566 (McAuliffe, J., dissenting) (quoting *Southern Pac. Terminal Co. v. International Communication Comm'n*, 219 U.S. 498, 515 (1974)).

181. *Mercy Hospital*, 62 Md. App. at 418, 489 A.2d at 1134.

182. *Id.* at 412, 489 A.2d at 1131.

183. *Id.* at 415, 489 A.2d at 1133.

184. *Id.* at 416, 489 A.2d at 1134. See MD. HEALTH-GEN. CODE ANN. § 20-107(b) (Supp. 1987).

185. *Mercy Hospital*, 62 Md. App. at 417, 489 A.2d at 1134.

186. *Id.* The court noted that the Patient's Bill of Rights as delineated by the Joint

The court of special appeals indicated in *Mercy Hospital* that it will respect a competent patient's right to decline medical treatment. As of yet the Maryland courts have not issued any decisions which determine the extent to which a competent person may instruct in advance for the termination of treatment. Other states, however, have indicated that there is no reason that the rights of a patient who formerly was competent should be more narrowly construed than those of a patient who is competent at the time of treatment.<sup>187</sup>

#### IV. PROGNOSIS AND PROPOSALS—A NEED FOR CLARIFICATION

The perimeters of the right to die are disturbingly unclear under Maryland's current legislative scheme. Because of what was considered a necessary compromise, the proposed Life-Sustaining Procedures Act was amended to include provisions limiting the withdrawal or withholding of food and water.<sup>188</sup> A study of the circumstances surrounding the Act's approval by the legislature yields the conclusion that the legislature intended the terms "food and water" to include AN&H. While Maryland's durable power of attorney statute carries no such restriction, the existing durable power of attorney is an unsure vehicle for making important medical decisions.

The legislature carefully should reexamine Maryland's natural death legislation in light of recent medical and judicial findings about AN&H. AN&H is not mere sustenance; it is an invasive form of medical treatment. As it stands, the Life-Sustaining Procedures Act fails to fulfill its basic purpose, *i.e.*, to recognize "the dignity which patients have a right to expect in making decisions concerning their own medical treatment."<sup>189</sup> A "gutted" living will statute is more dangerous in this respect than having no validating legislation at all. The existing legislation will discourage people from ex-

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Commission on Accreditation for Hospitals has been made applicable to Maryland hospitals by law. The Bill of Rights includes provisions mandating informed consent and the right to refuse treatment. *Id.* at n.8.

187. See, *e.g.*, *In re Conroy*, 98 N.J. 321, 353-55, 486 A.2d 1209, 1225-26 (1985). Looking to cases in other states involving blood transfusions to Jehovah's Witnesses, the *Conroy* court noted that when transfusions were authorized by courts, the patient's competency or the definiteness of the decision were at issue. Generally, patients are permitted to refuse medical treatment even at the risk of death, concluded the court. In the case before it, the court had no doubt that Ms. Conroy would have chosen the withdrawal of the nasogastric tube. *Id.* See Bamberger, *supra* note 179, at 518-21.

188. Life-Sustaining Procedures Act, ch. 620, 1985 Md. Laws 2944, 2945 (codified at MD. HEALTH-GEN. CODE ANN. § 5-605(1) (Supp. 1987)).

189. *Id.*

pressing in writing their wishes about AN&H. As a result, they may leave no evidence of their intent in this regard when they become incompetent. Persons who do include provisions about AN&H in their living wills do so without assurance that their effort to exercise the right to forego this type of treatment will be honored. Perhaps even more disturbing, prohibitions expressed in the Life-Sustaining Procedures Act may cast shadows of supposed state intent extending far beyond the Act's true confines. Even competent patients to whom living will legislation does not apply may be forced.

It also is unsatisfactory to piece together an alternate means of terminating treatment from statutes originally designed for other purposes. An overall statutory scheme pertaining to the right to forego treatment should be adopted in Maryland. Like the existing Life-Sustaining Procedures Act, it should validate the status of the living will. But authoring a living will is just one means of exercising the right to forego life-sustaining treatment. The new legislation also should provide for a durable power of attorney specifically designed for health care decisionmaking. The special durable power of attorney should enable advance designation of health care preferences in situations ranging from the routine to the life-threatening. In addition, guidelines for surrogate decisionmaking should be delineated in the context of the administration of life-sustaining treatment to enable family members and physicians to make treatment decisions for a patient who failed to author an advance directive.<sup>190</sup>

The new legislation should contain a blanket provision including AN&H within the definition of life-sustaining procedures which may be foregone. Nevertheless, provisions mandating continuation of comfort care, including natural forms of food and water, should remain. It is important that the legislature distinguish in this manner artificial and natural forms of nutrition and hydration. AN&H is

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190. As the cases previously discussed indicate, most people do not author advance directives. A recent survey of 803 people in Oregon indicated that although 82% of the participants had heard of a living will, only 16% responded that they or a member of their household possessed such a document. *The Latest Word*, 17 HASTINGS CENTER REP. 51 (Apr. 1987). Oregon has a natural death statute. See OR. REV. STAT. §§ 97-050 to -090 (1984 & Supp. 1987). A study of 500 nurses and 500 physicians revealed that only 20% possessed living wills or similar documents. Forty-eight percent responded that they were interested in signing a living will but had not yet done so. Anderson, Walker, Pierce & Mills, *Living Wills, Do Nurses and Physicians Have Them?*, AM. J. NURSING 271 (Mar. 1986). These surveys indicate that avenues other than the living will must be made available if the majority of people are to be allowed to exercise their right to forego life-sustaining treatment.

an invasive form of medical treatment which, like other medical treatment, may be discontinued under certain circumstances; however, the assurance of natural forms of food and water to the sick and dying remains a vital part of our humanity.

As an alternative to altering the definition of life-sustaining treatment, the Maryland legislature may wish to consider provisions similar to those recently enacted in Oklahoma presuming that "every incompetent patient has directed his health care providers to provide him with hydration and nutrition to a degree that is sufficient to sustain life."<sup>191</sup> This presumption, however, could be overridden by clear and convincing evidence that the patient when competent decided against such measures, when the measures themselves will cause severe, intractable and long-lasting pain, when the patient is irreversibly unconscious, or when death is imminent.<sup>192</sup> Again, the Maryland legislature should distinguish AN&H from other forms of food and water and ensure that only the former may be foregone.

The legislature is the appropriate forum for decisions of this nature.<sup>193</sup> As elected officials, state senators and delegates receive constant feedback from the citizens they represent. The legislature holds public hearings as forums for constituent opinion. Nevertheless, this process will continue to be thwarted when the position and power of select interest groups allow them to control the system. In the current political climate, it is unlikely that any amendment allowing for the discontinuation of AN&H will meet with success. This will remain true until the interest groups begin to accept the new view of AN&H.

If the legislature fails to act, the determination of AN&H as a form of medical treatment will be left to the judiciary. Maryland courts someday will be asked to rule whether a patient's request to have AN&H withheld or withdrawn will be honored despite the existing legislative provisions. This may occur when a Maryland resident who, interpreting the statutory language as ambiguous and

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191. Hydration and Nutrition for Incompetent Patients Act, 1987 Okla. Sess. Laws 180, 181 (codified at OKLA. STAT. tit. 63, §§ 3080.1 to .5 (Supp. 1988)).

192. *Id.* at 182. This language differs slightly from the Oklahoma statute in that it would include patients who are comatose or in a persistent vegetative state but whose death is not necessarily imminent. *Id.*

193. *See, e.g.,* Rasmussen v. Fleming, 154 Ariz. 207, 225, 741 P.2d 674, 692 (1987) ("Only the Legislature has the resources necessary to gather and synthesize the vast quantities of information needed to formulate guidelines that will best accommodate the rights and interests of the many individuals and institutions involved in these tragic situations.").

encouraged by decisions such as *Corbett*,<sup>194</sup> includes a supplementary provision in a living will specifically enumerating AN&H among the forms of terminable treatment. The question may be posed in the context of a nonresident who has written a living will under the laws of a home state allowing the termination of AN&H.<sup>195</sup> The court of special appeals' opinion in *Mercy Hospital*<sup>196</sup> is promising in this regard because it indicates that the court will continue to support the right to refuse treatment.

Determining the role of the court in this context goes to the heart of questions about judicial intervention. Perhaps a court should not be required to make decisions which are more ethical than legal in nature. Judicial proceedings may be drawn out and costly. Often the patient dies before his or her rights are determined. If the legislature fails to clarify the status of AN&H, however, Maryland courts should not evade their responsibility of affirming constitutional and common-law rights to forego nonconsensual forms of treatment. While it is true that exact factual patterns in cases involving the right to forego treatment never will be duplicated, the fundamental issues they raise almost certainly will.<sup>197</sup> The difficulty of these issues is exactly what makes them so important. Health care providers should be particularly anxious for these issues to be resolved. Not only is there the fear of prosecution for terminating treatment, but at least one court has found a possible cause of action for continuing treatment against the wishes of a patient or the patient's family.<sup>198</sup>

The status of AN&H in natural death legislation has moved to the foreground of right to die issues. This controversy did not suddenly spring from the minds of medical ethicists. It began when decisions such as *Barber* and *Conroy*, based upon new findings by

194. See *supra* notes 102-114 and accompanying text.

195. Living wills executed outside of Maryland by nonresidents are given effect in Maryland only if they comply with the Life-Sustaining Procedures Act. MD. HEALTH-GEN. CODE ANN. § 5-612(b) (Supp. 1987).

196. See *supra* notes 179-186 and accompanying text.

197. Several jurisdictions have made an exception to the mootness doctrine in cases involving the removal of life support systems where the patient died during the pendency of litigation. See, e.g., *Rasmussen*, 154 Ariz. at 213-14, 741 P.2d at 680-81; *Corbett*, 487 So. 2d at 369; *Conroy*, 98 N.J. at 342, 486 A.2d at 1219. These courts recognize that the issues underlying the particular proceedings do not perish with the patient; rather, they are of significant public importance, capable of repetition yet evading review. *Conroy*, 98 N.J. at 342, 486 A.2d at 1219.

198. *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 395, 469 N.E.2d 1047, 1051-52 (1984) (ruling that, as a matter of law, the placing of a patient in a chronic vegetative state on life support systems against her wishes created a cause of action for battery).

medical authorities, included AN&H among other forms of medical treatment. Interest groups such as the MCC reacted to these decisions by prompting legislatures to adopt new statutes or to amend existing legislation in order to curtail the right to forego AN&H. The most recent development in this progression is counteraction by courts in those jurisdictions which attempt to limit the right by statute. Courts are beginning to rule that natural death acts are not the sole means of exercising the right to die, and that they do not limit a court's ability to rule based upon common-law and constitutional rights.

The dispute is far from resolved. As of this writing, no state has reported a direct confrontation between the implementation of a living will requesting that AN&H be discontinued and a restrictive natural death act. When this confrontation occurs in Maryland, our courts should recognize firmly that an individual's right to forego treatment, including AN&H, remains paramount despite any legislative provision to the contrary.

WENDY ANN KRONMILLER\*

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